LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Program Integrity - Complaint Referral
Long Term-Personal Care Services

VISIT COMPLETED **AT REQUEST OF** LDH/MOLINA (check if "yes")	
VISIT COMPLETED **AFTER REVIEW OF** COMPLAINT FROM LDH/MOLINA (check if "yes")	

SECTION I: REPORTER INFORMATION

NAME	
TITLE (if applicable)	
TELEPHONE NUMBER	
EMAIL ADDRESS	

SECTION II: PROVIDER INFORMATION Provider Type 24 – LT-PCS/PCS/PAS (in-state only)

PROVIDER NAME	
MEDICAID ID/PROVIDER NUMBER	
PRIMARY CONTACT PERSON	
TELEPHONE NUMBER	
EMAIL ADDRESS	
REGION OF REFERRAL	

SECTION III: APPLICANT/RECIPIENT INFORMATION

NAME	
SOCIAL SECURITY NUMBER	
MEDICAID ID NUMBER	
HOME/SERVICE ADDRESS	
TELEPHONE NUMBER	
EMAIL ADDRESS	

SECTION IV: PRIMARY ALLEGATION(S) ("X" each applicable box)

FRAUDULENT BILLING	
FALSIFYING DOCUMENTS/FORGING SIGNATURES	
EVV	
OTHER (provide detailed description in summary)	

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

SECTION V: DATE(S) OF SERVICE OF ALLEGATION(S)

SECTION VI: RECIPIENT SERVICES AND ASSESSMENT DESCRIPTION

NUMBER OF LT-PCS HOURS APPROVED PER WEEK	
NAME OF PRIMARY DIRECT SERVICE WORKER	
DSW PRESENT DURING ASSESSMENT/VISIT (Y/N)	
RELATIONSHIP OF DSW TO RECIPIENT (if applicable)	

SECTION VII: SUMMARY OF FINDINGS

DESCRIPTIVE SUMMARY: Using bullet format, indicate dates and times, observations, statements/quotes, and names/relationships of all present. Specific details, not otherwise noted above, should be described in detail here.
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SECTION VIII: PI CONTACT INFORMATION

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